		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028860

Facility Name: Lexington Health Care Center-Lombard

Address: 2100 S. Finley Road (Number) Lombard (City) 60148 (Zip Code)

County: DuPage

Telephone Number: (630) 495-4000 **Fax #** (630) 495-2809

IDPA ID Number: 363252724001

Date of Initial License for Current Owners: 10/09/84

Type of Ownership:

	VOLUNTARY,NON-PROFIT			x	PROPRIETARY		GOVERNMENTAL
		Charitable Corp.			Individual		State
		Trust			Partnership		County
IRS Exemption Code					Corporation		Other
				x	"Sub-S" Corp.		
					Limited Liability Co.		
					Trust		
					Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser, LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	224	Skilled (SNF)	224	81,760	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	224	TOTALS	224	81,760	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,230	15,798	9,401	31,429	8
9	SNF/PED					9
10	ICF	28,270	14,208	491	42,969	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,500	30,006	9,892	74,398	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.00%

D. How many bed-hold days during this year were paid by Public Aid?
27 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/9/84

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 46 and days of care provided 7,810

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	338,123	29,375	11,454	378,952		378,952		378,952			1
2	Food Purchase		288,718		288,718		288,718	(12,086)	276,632			2
3	Housekeeping	346,369	38,897		385,266		385,266	771	386,037			3
4	Laundry	32,408	23,480		55,888		55,888	(13,614)	42,274			4
5	Heat and Other Utilities			253,792	253,792		253,792	4,117	257,909			5
6	Maintenance	77,208		134,503	211,711		211,711	7,972	219,683			6
7	Other (specify):*											7
8	**TOTAL General Services**	794,108	380,470	399,749	1,574,327		1,574,327	(12,840)	1,561,487			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,217,214	225,876	15,153	3,458,243		3,458,243		3,458,243			10
10a	Therapy			731,389	731,389		731,389		731,389			10a
11	Activities	252,709	17,305	3,149	273,163		273,163		273,163			11
12	Social Services	79,086		2,543	81,629		81,629		81,629			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,549,009	243,181	776,234	4,568,424		4,568,424		4,568,424			16
	C. General Administration											
17	Administrative	203,614		460,464	664,078		664,078	(460,464)	203,614			17
18	Directors Fees											18
19	Professional Services			36,748	36,748		36,748	9,098	45,846			19
20	Dues, Fees, Subscriptions & Promotions			20,125	20,125		20,125	1,589	21,714			20
21	Clerical & General Office Expenses	469,298	45,948	33,925	549,171		549,171	14,752	563,923			21
22	Employee Benefits & Payroll Taxes			666,139	666,139		666,139	72,601	738,740			22
23	Inservice Training & Education			1,906	1,906		1,906		1,906			23
24	Travel and Seminar			1,452	1,452		1,452	3,232	4,684			24
25	Other Admin. Staff Transportation			43	43		43	10,600	10,643			25
26	Insurance-Prop.Liab.Malpractice			182,607	182,607		182,607	3,522	186,129			26
27	Other (specify):*											27
28	**TOTAL General Administration**	672,912	45,948	1,403,409	2,122,269		2,122,269	(345,070)	1,777,199			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,016,029	669,599	2,579,392	8,265,020		8,265,020	(357,910)	7,907,110			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Lexington Health Care Center-Lombard #0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			66,293	66,293		66,293	142,435	208,728			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			661	661		661	220,323	220,984			32
33	Real Estate Taxes							142,901	142,901			33
34	Rent-Facility & Grounds			1,341,587	1,341,587		1,341,587	(1,341,587)				34
35	Rent-Equipment & Vehicles			4,165	4,165		4,165	4,868	9,033			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,412,706	1,412,706		1,412,706	(831,060)	581,646			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		171,231	41,739	212,970		212,970		212,970			39
40	Barber and Beauty Shops			43,486	43,486		43,486		43,486			40
41	Coffee and Gift Shops			434	434		434		434			41
42	Provider Participation Fee			122,640	122,640		122,640		122,640			42
43	Other (specify):* Nonallowable Costs			126,771	126,771		126,771	(126,771)				43
44	**TOTAL Special Cost Centers**		171,231	335,070	506,301		506,301	(126,771)	379,530			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,016,029	840,830	4,327,168	10,184,027		10,184,027	(1,315,741)	8,868,286			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(66)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(13,614)	4		8
9	Non-Straightline Depreciation	1,178	30		9
10	Interest and Other Investment Income	(2,107)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,003)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(82,294)	43		24
25	Fund Raising, Advertising and Promotional	(16,474)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(38,724)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(6,376)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (160,480)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,155,261)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (1,155,261)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (1,315,741)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Lexington Health Care Center-Lombard

ID# 0028860

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Lexington Health Care Center of Lombard, Inc.
Provider # 0028860
1/1/02 - 12/31/02 **Schedule A**

Schedule VI. Adjustment detail
Line 29, Other

Description	Amount	Reference
Non-allowable collections expense	(1,665)	19
Non-allowable Chamber of Commerce dues	(460)	20
Offset miscellaneous income	(604)	21
Nonallowable miscellaneous expense	(10,485)	21
Amortized deferred maintenance	6,838	6
Total	(6,376)	

See Accountants' Compilation Report

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(66)	0	0	0	0	0	0	0	0	0	0	(66)	2
3	Housekeeping	0	0	771	0	0	0	0	0	0	0	0	771	3
4	Laundry	(13,614)	0	0	0	0	0	0	0	0	0	0	(13,614)	4
5	Heat and Other Utilities	0	0	4,117	0	0	0	0	0	0	0	0	4,117	5
6	Maintenance	0	0	1,134	0	0	0	0	0	0	0	0	1,134	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(13,680)	0	6,022	0	0	0	0	0	0	0	0	(7,658)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(460,464)	0	0	0	0	0	0	0	(460,464)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	83	10,680	0	0	0	0	0	0	0	0	10,763	19
20	Fees, Subscriptions & Promotions	0	0	2,049	0	0	0	0	0	0	0	0	2,049	20
21	Clerical & General Office Expenses	0	555	25,286	0	0	0	0	0	0	0	0	25,841	21
22	Employee Benefits & Payroll Taxes	0	0	60,581	0	0	0	0	0	0	0	0	60,581	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,232	0	0	0	0	0	0	0	0	3,232	24
25	Other Admin. Staff Transportation	0	0	0	10,600	0	0	0	0	0	0	0	10,600	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	3,522	0	0	0	0	0	0	0	3,522	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	638	101,828	(446,342)	0	0	0	0	0	0	0	(343,876)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(13,680)	638	107,850	(446,342)	0	0	0	0	0	0	0	(351,534)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,178	112,701	0	28,556	0	0	0	0	0	0	0	142,435	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,107)	217,809	0	4,621	0	0	0	0	0	0	0	220,323	32
33	Real Estate Taxes	0	140,587	0	2,314	0	0	0	0	0	0	0	142,901	33
34	Rent-Facility & Grounds	0	(1,341,587)	0	0	0	0	0	0	0	0	0	(1,341,587)	34
35	Rent-Equipment & Vehicles	0	0	0	4,868	0	0	0	0	0	0	0	4,868	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(929)	(870,490)	0	40,359	0	0	0	0	0	0	0	(831,060)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(139,495)	12,724	0	0	0	0	0	0	0	0	0	(126,771)	43
44	**TOTAL Special Cost Centers**	(139,495)	12,724	0	0	0	0	0	0	0	0	0	(126,771)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(154,104)	(857,128)	107,850	(405,983)	0	0	0	0	0	0	0	(1,309,365)	45

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas	33.33%			Lexington Health		
John Samatas	33.33%	See Attached Schedule B	See Attached	Care Systems of		
Cynthia Thiem	33.34%		Schedule B	Lombard Ltd. Ptsp.	Lombard	Real Estate Ptsp.
				Royal Mgmt. Corp.	Lombard	Mgmt. Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 1,341,587	Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	$	$ (1,341,587)	1
2	V	19	Professional fees		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	83	83	2
3	V	21	Bank charges		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	555	555	3
4	V	30	Depreciation		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	112,701	112,701	4
5	V	32	Interest expense		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	215,355	215,355	5
6	V	32	Amortization of mortgage costs		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	2,454	2,454	6
7	V	33	Property taxes		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	140,587	140,587	7
8	V	43	State replacement tax		Lexington Health Care Systems of Lombard Ltd. Ptsp.	**	12,724	12,724	8
9	V								9
10	V								10
11	V								11
12	V				** - The owners of Lexington Health Care Center of Lombard, Inc. own				12
13	V				100% of Lexington Health Care Systems of Lombard Limited Partnership				13
14	Total			$ 1,341,587			$ 484,459	$ * (857,128)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Lombard, Inc.
Provider # 0028660 **Schedule B**
1/1/02 - 12/31/02

VII. Related Parties
Related Nursing Homes

Name of facility	City
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 771	$ 771	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	3,921	3,921	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	196	196	17
18	V	6	Repairs & maintenance		Royal Management Corp.	**	1,068	1,068	18
19	V	6	Scavenger & exterminating		Royal Management Corp.	**	49	49	19
20	V	6	Security service		Royal Management Corp.	**	17	17	20
21	V	19	Computer consultant & supplies		Royal Management Corp.	**	8,509	8,509	21
22	V	19	Professional fees		Royal Management Corp.	**	2,171	2,171	22
23	V	20	Advertising - help wanted		Royal Management Corp.	**	1,232	1,232	23
24	V	20	Dues & subscriptions		Royal Management Corp.	**	817	817	24
25	V	21	Bank charges		Royal Management Corp.	**	2,839	2,839	25
26	V	21	Communications		Royal Management Corp.	**	567	567	26
27	V	21	Office supplies & printing		Royal Management Corp.	**	10,757	10,757	27
28	V	21	Postage		Royal Management Corp.	**	3,379	3,379	28
29	V	21	Telephone		Royal Management Corp.	**	7,744	7,744	29
30	V	22	FICA		Royal Management Corp.	**	32,654	32,654	30
31	V	22	FUTA		Royal Management Corp.	**	601	601	31
32	V	22	SUTA		Royal Management Corp.	**	655	655	32
33	V	22	Insurance - W/C		Royal Management Corp.	**	757	757	33
34	V	22	Insurance - hospitalization		Royal Management Corp.	**	18,994	18,994	34
35	V	22	401(k) and other emp. benefits		Royal Management Corp.	**	6,920	6,920	35
36	V	24	Travel & seminar		Royal Management Corp.	**	3,232	3,232	36
37	V								37
38	V		**Certain owners of Lexington Health Care Center of Lombard, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 107,850	$ * 107,850	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	Auto expense	$	Royal Management Corp.	**	$ 10,600	$ 10,600	15
16	V	26	Insurance - general		Royal Management Corp.	**	3,522	3,522	16
17	V	30	Depreciation - vehicles		Royal Management Corp.	**	3,781	3,781	17
18	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	7,425	7,425	18
19	V	30	Depreciation - equipment		Royal Management Corp.	**	17,350	17,350	19
20	V	32	Interest		Royal Management Corp.	**	4,621	4,621	20
21	V	33	Property taxes		Royal Management Corp.	**	2,314	2,314	21
22	V	35	Equipment rental		Royal Management Corp.	**	4,868	4,868	22
23	V	17	Management fees	460,464	Royal Management Corp.	**		(460,464)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		**Certain owners of Lexington Health Care Center of Lombard, Inc. own 100% of Royal Management Corp.						38
39	Total			$ 460,464			$ 54,481	$ * (405,983)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	33.33%	See Schedule C	5	11%	Salary	$ 39,901	L 17, C 1	1
2	John Samatas	Owner/officer	Admin/Plant Ops.	33.33%	See Schedule C	2	10%	Salary	17,734	L 17, C 1	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34%	See Schedule C	2	10%	Salary	22,167	L 17, C 1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	10%	Salary	5,320	L 17, C 1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	6	12%	Salary	13,437	L 17, C 1	5
6											6
7											7
8						All individuals work in excess of 40 hours per week.						8
9											9
10											10
11											11
12											12
13								TOTAL	$ 98,559		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Lexington Health Care Center of Lombard, Inc.
Provider # 0028660 **Schedule C**
1/1/02 - 12/31/02

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

Name of facility	John Samatas	James Samatas	Cynthia Thiem	George Samatas	Jason Samatas	Total
Lexington Health Care Center of Bloomingdale, Inc.	13,617	30,638	17,021	4,085	10,318	75,679
Lexington Health Care Center of Chicago Ridge, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Elmhurst, Inc.	11,875	26,719	14,844	3,563	8,998	65,999
Lexington Health Care Center of LaGrange, Inc.	8,629	19,416	10,787	2,589	6,538	47,959
Lexington Health Care Center of Lake Zurich, Inc.	16,071	36,160	20,089	4,821	12,177	89,318
Lexington Health Care Center of Orland Park, Inc.	21,376	48,096	26,721	6,413	16,194	118,800
Lexington Health Care Center of Schaumburg, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Streamwood, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Wheeling, Inc.	17,496	39,367	21,870	5,249	13,258	97,240
Total	142,266	320,099	177,833	42,680	107,794	790,672

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	737,665	10	$ 6,954	$	81,760	$ 771	1
2	5	Utilities - gas & electric	Bed Days	737,665	10	35,380		81,760	3,921	2
3	5	Utilities - water & sewer	Bed Days	737,665	10	1,765		81,760	196	3
4	6	Repairs & maintenance	Bed Days	737,665	10	9,640		81,760	1,068	4
5	6	Scavenger & exterminating	Bed Days	737,665	10	438		81,760	49	5
6	6	Security service	Bed Days	737,665	10	150		81,760	17	6
7	19	Computer consultant & supplies	Bed Days	737,665	10	76,767		81,760	8,509	7
8	19	Professional fees	Bed Days	737,665	10	19,590		81,760	2,171	8
9	20	Advertising - help wanted	Bed Days	737,665	10	11,111		81,760	1,232	9
10	20	Dues & subscriptions	Bed Days	737,665	10	7,373		81,760	817	10
11	21	Bank charges	Bed Days	737,665	10	25,613		81,760	2,839	11
12	21	Communications	Bed Days	737,665	10	5,118		81,760	567	12
13	21	Office supplies & printing	Bed Days	737,665	10	97,051		81,760	10,757	13
14	21	Postage	Bed Days	737,665	10	30,484		81,760	3,379	14
15	21	Telephone	Bed Days	737,665	10	69,873		81,760	7,744	15
16	22	FICA	Bed Days	737,665	10	294,613		81,760	32,654	16
17	22	FUTA	Bed Days	737,665	10	5,419		81,760	601	17
18	22	SUTA	Bed Days	737,665	10	5,907		81,760	655	18
19	22	Insurance - W/C	Bed Days	737,665	10	6,829		81,760	757	19
20	22	Insurance - hospitalization	Bed Days	737,665	10	171,371		81,760	18,994	20
21	22	401(k) and other emp. benefits	Bed Days	737,665	10	62,427		81,760	6,920	21
22	24	Travel & seminar	Bed Days	737,665	10	29,161		81,760	3,232	22
23										23
24										24
25	TOTALS					$ 973,034	$		$ 107,850	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	737,665	10	$ 95,636	$	81,760	$ 10,600	1
2	26	Insurance - general	Bed Days	737,665	10	31,776		81,760	3,522	2
3	30	Depreciation - vehicles	Bed Days	737,665	10	34,112		81,760	3,781	3
4	30	Depreciation - leasehold improv.	Bed Days	737,665	10	66,995		81,760	7,425	4
5	30	Depreciation - equipment	Bed Days	737,665	10	156,541		81,760	17,350	5
6	32	Interest	Bed Days	737,665	10	41,692		81,760	4,621	6
7	33	Property taxes	Bed Days	737,665	10	20,881		81,760	2,314	7
8	35	Equipment rental	Bed Days	737,665	10	43,917		81,760	4,868	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 491,550	$		$ 54,481	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	GMAC		x	Mortgage	$39,766.00	04/11/94	$ 3,978,766	$ 2,336,644	04/11/09	0.0875	$ 215,355	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LaSalle Bank N.A.		x	Line of Credit	Varies	04/6/02	750,000	200,000	04/05/03	0.0425	661	6
7												7
8												8
9	TOTAL Facility Related				$39,766.00		$ 4,728,766	$ 2,536,644			$ 216,016	9
	B. Non-Facility Related*											
10								Interest income offset			(2,107)	10
11								Amortization of mortgage costs			2,454	11
12								Allocation from management company			4,621	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 4,968	14
15	TOTALS (line 9+line14)						$ 4,728,766	$ 2,536,644			$ 220,984	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.		$ 138,000	1
	Allocated from management company	2,314	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2001	$ 137,587	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,901	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 141,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 142,901	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	130,718	8
	1998	134,318	9
	1999	135,483	10
	2000	133,908	11
	2001	137,587	12

2001 tax:	137,587
Estimated increase:	1.025
Estimated 2002 taxes:	141,027
Use:	141,000

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center-Lombarc COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0028860

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-19-307-002	Land and building	$ 137,587.36	$ 137,587.36
2.	Royal Management Corp. (Omni Partners)		$	$
3.	06-19-201-018	Land and building	$ 70,162.04	$ 162.00
4.	Royal Management Corp. (Samvest		$	$
5.	05-01-202-019	Land and building	$ 144,399.48	$ 2,152.00
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 352,148.88	$ 139,901.36

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 78,770 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Lombard Lexington Square Life Care, Inc.: Retirement Community; 261 units; 309,000 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	30,000	1984	$ 616,761	1
2	Allocated from management company			18,045	2
3	TOTALS	30,000		$ 634,806	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	215		1984	1984	$ 3,661,473	$	35	$ 104,614	$ 104,614	$ 1,907,014	4
5	9		1995	1995	284,156	8,119	35	8,119		60,890	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1990	96,217		10			96,217	9
10	Building Improvements			1991	71,493		10	597	597	71,493	10
11	Building Improvements			1994	20,200		10	2,020	2,020	17,170	11
12	Building Improvements			1995	14,535	415	35	415		3,115	12
13	Building Improvements - dishwater hooc			1996	2,748	275	10	275		1,786	13
14	Building Improvements - outside painting			1996	11,308	1,131	10	1,131		7,350	14
15	Building Improvements - dining room			1996	3,752	375	10	375		2,439	15
16	Leasehold Improvements			1992	16,299	466	35	466		4,891	16
17	Leasehold Improvements			1994	21,836	2,184	10	2,184		18,560	17
18	Leasehold Improvements - 2nd floor			1996	19,319	1,932	10	1,932		12,557	18
19	Leasehold Improvements - bathroom rehat			1996	9,216	922	10	922		5,991	19
20	Leasehold Improvements - fan coil repairs			1996	6,669	191	35	191		1,207	20
21	Land Improvements			1993	2,985	199	15	199		1,891	21
22	Land Improvements			1995	4,596	306	15	306		2,298	22
23	Capitalized Repairs			1986	1,730		10			1,730	23
24	Building Improvements - basement			1996	18,993	1,899	10	1,899		10,921	24
25	Leasehold Improvements - Corner Guards			1997	520	52	10	52		286	25
26	Leasehold Improvements - Corridor flooring			1997	10,381	1,038	10	1,038		5,709	26
27	BI: Kitchen Rehab			1998	2,494	249	10	249		1,122	27
28	Wiring for MDS project			1998	3,365	337	10	337		1,515	28
29	Install Fire Sprinklers in Mechanical Rms			1998	4,600	131	35	131		591	29
30	Tile for Lobby			1998	20,530	2,053	10	2,053		9,239	30
31	Walk in Freezers/Coolers			1998	3,182	91	35	91		409	31
32	Fire Wall Repairs			1998	12,410	355	35	355		1,596	32
33	Underground storage tank			1998	2,613		10	262	262	1,310	33
34	Repave parking lot			1999	7,625	508	15	508		1,779	34
35	Lounge Floor Tile			1999	2,964	296	10	296		1,037	35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Rewire Building	1999	$ 9,083	$ 260	35	$ 260	$	$ 908	37
38	Heat exchanger for water heater	1999	1,660		5	332	332	1,162	38
39	Compressor and tank for freezer	1999	2,924		5	584	584	2,045	39
40	Plumbing Improvements	2000	2,833	283	10	283		708	40
41	Relocate 2nd floor sprinklers	2000	2,200	63	35	63		157	41
42	Water heater repairs	2000	3,831	766	5	766		1,916	42
43	Automatic door	2000	4,556	130	35	130		325	43
44	Install sprinklers	2001	6,082	608	10	608		963	44
45	Infrared curtains for elevator	2001	4,500	450	10	450		525	45
46	Elevator upgrade	2002	3,006	301	5	301		301	46
47	Condensor	2002	2,678	268	5	268		268	47
48									48
49									49
50									50
51	Leasehold improvements - management company	1995	11,437		35	415	415	2,451	51
52	Leasehold improvements - management company	1996	9,308		35	338	338	1,729	52
53	Leasehold improvements - management company	1989	321		31	12	12	151	53
54	HVAC - management company	1998	241		35	9	9	34	54
55	Offices - management company	1999	608		35	22	22	61	55
56	Offices - management company	2000	289		35	10	10	23	56
57	Land improvements - management company	2002	10,824		15	661	661	661	57
58	Building - management company	2002	252,340		40	5,783	5,783	5,783	58
59	Sewer & water improvements - management company	2002	5,740		30	175	175	175	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,672,670	$ 26,653		$ 142,487	$ 115,834	$ 2,272,459	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 338,246	$ 30,524	$ 35,397	$ 4,873	5-10 years	$ 216,776	71
72	Current Year Purchases	194,253	9,713	9,713		10 years	9,713	72
73	Fully Depreciated Assets	865,266					865,266	73
74	Allocated from management company	173,290		17,350	17,350		45,327	74
75	TOTALS	$ 1,571,055	$ 40,237	$ 62,460	$ 22,223		$ 1,137,082	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79	Allocated from Management Company			33,843		3,781	3,781		23,551	79
80	TOTALS			$ 33,843	$	$ 3,781	$ 3,781		$ 23,551	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,912,374	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 66,890	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 208,728	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 141,838	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,433,092	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Facility Rehabilitation	$ 679,043	92
93			93
94			94
95		$ 679,043	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 9,033 Description: Postage Meter - $626; Copier - $3539; Allocated from Management Company - $4,868
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
[ ] YES
[X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L 10A, C 3	hrs	$	22,458	$ 307,397	$	22,458	$ 307,397	1
2	Licensed Speech and Language Development Therapist	L 10A, C 3	hrs		3,888	63,113		3,888	63,113	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L 10A, C 3	hrs		33,996	360,879		33,996	360,879	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39, C 2	# of prescrpts				171,231		171,231	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See attached Schedule D					41,739			41,739	13
14	TOTAL			$	60,342	$ 773,128	$ 171,231	60,342	$ 944,359	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center-Lombard
Provider #: 0028860
01/01/02 to 12/31/02

Schedule D

Schedule XIV. Special Services
Line 13, Other

Service	Cost	Line Reference
Clinitron Beds	17,227	L 39, C 3
Oxygen	18,174	L 39, C 3
Laboratory	3,129	L 39, C 3
Radiology	3,209	L 39, C 3
Total	41,739	

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 547,034	$ 548,786	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 381,492)	2,070,425	2,070,425	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	71,574	71,574	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	49,262	49,262	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,738,295	$ 2,740,047	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		634,806	13
14	Buildings, at Historical Cost		3,661,472	14
15	Leasehold Improvements, at Historical Cost	523,253	1,011,198	15
16	Equipment, at Historical Cost	438,038	1,604,898	16
17	Accumulated Depreciation (book methods)	(323,177)	(3,433,092)	17
18	Deferred Charges		2,781	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Construction in progr	679,043	679,043	22
23	Other(specify): Unamortized loan costs		15,545	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,317,157	$ 4,176,651	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,055,452	$ 6,916,698	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 390,915	$ 390,915	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,701	15,701	28
29	Short-Term Notes Payable	200,000	200,000	29
30	Accrued Salaries Payable	236,236	236,236	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,038	3,038	31
32	Accrued Real Estate Taxes(Sch.IX-B)		141,000	32
33	Accrued Interest Payable		11,400	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	180,508	183,765	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,026,398	$ 1,182,055	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,336,644	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,336,644	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,026,398	$ 3,518,699	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,029,054	$ 3,397,999	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,055,452	$ 6,916,698	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of Lombard, Inc.
Provider # 0028860
1/1/02 - 12/31/02 **Schedule E**

XV. Balance Sheet
C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Accrued Rent	61,743	-
Accrued management fees	31,455	31,455
Accrued 401 (k) contribution	18,141	18,141
401 (k) withholding	4,966	4,966
Other accrued expenses	53,756	53,756
Due to related party	10,447	10,447
Due to partners	-	65,000
Total line 36	180,508	183,765

XVII. Income Statement
E. Other Revenue

28. Other Revenue

Description	Amount
Gain on sale	1,500
Service Availability Fee	530,528
Miscellaneous Income	604
Total line 28	532,632

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,035,065	1
2	Restatements (describe):		2
3	**Prior period adjustment**	(100,064)	3
4	**Prior year's post closing entries**	(156,836)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,778,165	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,431,889	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(2,181,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 250,889	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,029,054	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,005,983	1
2	Discounts and Allowances for all Levels	(597,187)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,408,796	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,281,047	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,281,047	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	467	12
13	Barber and Beauty Care	51,586	13
14	Non-Patient Meals	66	14
15	Telephone, Television and Radio	202	15
16	Rental of Facility Space		16
17	Sale of Drugs	207,202	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,171	19
20	Radiology and X-Ray	3,437	20
21	Other Medical Services	97,589	21
22	Laundry	13,614	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 391,334	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,107	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,107	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See attached Schedule E**	532,632	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 532,632	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,615,916	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,574,327	31
32	Health Care	4,568,424	32
33	General Administration	2,122,269	33
	B. Capital Expense		
34	Ownership	1,412,706	34
	C. Ancillary Expense		
35	Special Cost Centers	383,661	35
36	Provider Participation Fee	122,640	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,184,027	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,431,889	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,431,889	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity files a cash basis tax return

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,615	2,794	$ 105,462	$ 37.75	1
2	Assistant Director of Nursing	4,009	4,200	115,052	27.39	2
3	Registered Nurses	41,713	44,817	1,149,662	25.65	3
4	Licensed Practical Nurses	18,579	20,058	468,319	23.35	4
5	Nurse Aides & Orderlies	103,112	108,796	1,219,097	11.21	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,075	12,019	159,622	13.28	8
9	Activity Director	2,158	2,345	24,194	10.32	9
10	Activity Assistants	22,304	23,589	228,515	9.69	10
11	Social Service Workers	3,959	4,146	79,086	19.08	11
12	Dietician					12
13	Food Service Supervisor	1,847	2,070	33,500	16.18	13
14	Head Cook	1,911	2,070	38,200	18.45	14
15	Cook Helpers/Assistants	14,720	15,729	147,431	9.37	15
16	Dishwashers	17,387	18,455	118,992	6.45	16
17	Maintenance Workers	4,392	4,736	77,208	16.30	17
18	Housekeepers	45,582	48,437	346,369	7.15	18
19	Laundry	4,874	5,065	32,408	6.40	19
20	Administrator	2,203	2,301	105,055	45.66	20
21	Assistant Administrator					21
22	Other Administrative	737	737	98,559	133.73	22
23	Office Manager					23
24	Clerical	24,246	26,267	469,298	17.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	327,423	348,631	$ 5,016,029 *	$ 14.39	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	228	$ 11,454	L 1, C 3	35
36	Medical Director	Monthly	24,000	L 9, C 3	36
37	Medical Records Consultant	13	650	L 10, C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	67	3,149	L 11, C 3	44
45	Social Service Consultant	Monthly	2,543	L 12, C 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	308	$ 42,996		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nancy McDonald	Administrator	0.00%	$ 105,055
John Samatas	Admin/Plant Ops.	33.33%	17,734
James Samatas	Administrative	33.33%	39,901
Cynthia Thiem	Administrative	33.34%	22,167
George Samatas	Administrative	0.00%	5,320
Jason Samatas	Administrative	0.00%	13,437
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 203,614

B. Administrative - Other

Description	Amount
Management fees (eliminated in Column 7)	$ 460,464
TOTAL (agree to Schedule V, line 17, col. 3)	$ 460,464
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ING	401(k) Administration	$ 780
Altschuler, Melvoin & Glasser LLP	Accounting	14,703
American Express Tax & Bus. Svs.	Accounting	5,405
Harris, Kessler & Goldstein	Legal	3,500
Sachnoff & Weaver	Legal	1,971
James Samatas	Legal	125
Personnel Planners	U/C Consultant	1,241
Internet Presence Consulting	Computer Consulting	711
Systematic Management	Billing Consultant	58
Freedman, Anselmo & Lindberg	Collections	1,665
Katten Muchin, Zavis & Rosenman	Legal	868
See attached Schedule F		5,721
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 36,748

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 91,591
Unemployment Compensation Insurance	30,153
FICA Taxes	371,925
Employee Health Insurance	155,717
Employee Meals	12,020
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contribution	21,516
Employee Transportation	42,534
Other Employee Benefits	13,284
TOTAL (agree to Schedule V, line 22, col.8)	$ 738,740

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	15,855
Health Care Worker Background Check	
(Indicate # of checks performed 56)	664
Miscellaneous Licenses & Permits	1,834
Miscellaneous Dues & Subscriptions	1,312
Allocated from Management Company	2,049
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,714

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,452
Allocated from Management Company	3,232
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,684

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Lombard, Inc.
Provider # 0028860 **Schedule F**
1/1/02 - 12/31/02

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Carol Jeschke	Staffing Consultant	738
Glantz-Richman	Rehabilitation Consultant	350
Information Controls, Inc.	Computer Consultant	867
Gigatrend	Computer Consultant	195
Action Computer Services	Computer Consultant	324
Advanced Answers on Demand, Inc.	Computer Consultant	3,247
		5,721
Total, Agrees to Schedule V, Line 19, Column 3		36,748
Allocated from management co.		
Altschuler, Melvoin & Glasser, LLP/ American Express Tax & Business Services	Accounting	809
Brekke Consulting, Inc.	Exec. Counsel Consulting	187
Gilson, Labus and Silverman	Accounting	50
James Samatas	Legal	22
Katten, Muchin, Zavis and Rosenman	Legal	245
Sachnoff and Weaver	Legal	134
ING / Pension Administrators / Aetna Life Insurance & Annuity Co	401 (k) Administration	600
Various	Consulting	8,633
Allocated from building partnership		
James Samatas	Filing and recording fees	83
Nonallowable legal fees		
Freedman, Anselmo, & Lindberg	Legal-collection fees	(1,665)
Total, Agrees to Schedule V, Line 19, Column 8		45,846

See accountants' compilation report.

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Deferred Maintenance	1999	$ 2,219	36 mo.	$ 370	$ 740	$ 740	$ 369	$	$	$	$	$
2	Deferred Maintenance	3/1999	1,536	36 mo.	256	512	512	256					
3	Deferred Maintenance	9/1999	3,918	36 mo.	653	1,306	1,306	653					
4	Painting & Decorating	2000	16,681	36 mo.		2,780	5,560	5,560	2,781				
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 24,354		$ 1,279	$ 5,338	$ 8,118	$ 6,838	$ 2,781	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Lombard # 0028860 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **56,367** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **x** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **122,640**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **12,020** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **66**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Lexington Health Care C** **03:21 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-1,315,741	equal to	-1,315,741	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	220,984	equal to	220,984	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	142,901	equal to	142,901	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	208,728	equal to	208,728	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	9,033	equal to	9,033	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	731,389	equal to	731,389	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	171,231	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,574,327	equal to	1,574,327	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,568,424	equal to	4,568,424	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	2,122,269	equal to	2,122,269	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	1,412,706	equal to	1,412,706	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	383,661	equal to	383,661	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	122,640	equal to	122,640	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	3,057,592	equal to	3,217,214	-159,622	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	252,709	equal to	252,709	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	79,086	equal to	79,086	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	338,123	equal to	338,123	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	77,208	equal to	77,208	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	346,369	equal to	346,369	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	32,408	equal to	32,408	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	203,614	equal to	203,614	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	469,298	equal to	469,298	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	5,016,029	equal to	5,016,029	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	11,454	< or = to	11,454	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	24,000	< or = to	24,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,850	< or = to	15,153	-13,303	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	3,149	< or = to	3,149	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,543	< or = to	2,543	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	203,614	equal to	203,614	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	460,464	equal to	460,464	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	36,748	equal to	36,748	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	738,740	equal to	738,740	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	21,714	equal to	21,714	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	4,684	equal to	4,684	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	122,640	equal to	122,640	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	12,020	< or = to	72,601	-60,581	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	12,020	equal to	12,020	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	7,810	equal to	9,401	-1,591	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-1,155,261	equal to	-1,155,261	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	2,536,644	equal to	2,536,644	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	141,000	equal to	141,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	634,806	equal to	634,806	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	4,672,670	equal to	4,672,670	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,604,898	equal to	1,604,898	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	3,433,092	equal to	3,433,092	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	3,029,054	equal to	3,029,054	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	2,431,889	equal to	2,431,889	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	2,781	equal to	2,781	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	4,055,452	equal to	4,055,452	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	338,123	29,375	11,454	378,952	0	378,952	0	378,952
2. Food P	0	288,718	0	288,718	0	288,718	-12,086	276,632
3. Housek	346,369	38,897	0	385,266	0	385,266	771	386,037
4. Laundry	32,408	23,480	0	55,888	0	55,888	-13,614	42,274
5. Heat ar	0	0	253,792	253,792	0	253,792	4,117	257,909
6. Mainter	77,208	0	134,503	211,711	0	211,711	7,972	219,683
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	794,108	380,470	399,749	1,574,327	0	1,574,327	-12,840	1,561,487
9. Medical	0	0	24,000	24,000	0	24,000	0	24,000
10. Nursin	3,217,214	225,876	15,153	3,458,243	0	3,458,243	0	3,458,243
10a. Thera	0	0	731,389	731,389	0	731,389	0	731,389
11. Activiti	252,709	17,305	3,149	273,163	0	273,163	0	273,163
12. Social	79,086	0	2,543	81,629	0	81,629	0	81,629
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total I	3,549,009	243,181	776,234	4,568,424	0	4,568,424	0	4,568,424
17. Admin	203,614	0	460,464	664,078	0	664,078	-460,464	203,614
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	36,748	36,748	0	36,748	9,098	45,846
20. Fees,	0	0	20,125	20,125	0	20,125	1,589	21,714
21. Clerica	469,298	45,948	33,925	549,171	0	549,171	14,752	563,923
22. Emplo	0	0	666,139	666,139	0	666,139	72,601	738,740
23. Inserv	0	0	1,906	1,906	0	1,906	0	1,906
24. Travel	0	0	1,452	1,452	0	1,452	3,232	4,684
25. Other	0	0	43	43	0	43	10,600	10,643
26. Insura	0	0	182,607	182,607	0	182,607	3,522	186,129
27. Other	0	0	0	0	0	0	0	0
28. Total (	672,912	45,948	1,403,409	2,122,269	0	2,122,269	-345,070	1,777,199
29. Total (	5,016,029	669,599	2,579,392	8,265,020	0	8,265,020	-357,910	7,907,110
30. Depre	0	0	66,293	66,293	0	66,293	142,435	208,728
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	661	661	0	661	220,323	220,984
33. Real E	0	0	0	0	0	0	142,901	142,901
34. Rent -	0	0	1,341,587	1,341,587	0	1,341,587	########	0
35. Rent -	0	0	4,165	4,165	0	4,165	4,868	9,033
36. Other	0	0	0	0	0	0	0	0
37. Total (	0	0	1,412,706	1,412,706	0	1,412,706	-831,060	581,646
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	171,231	41,739	212,970	0	212,970	0	212,970
40. Barber	0	0	43,486	43,486	0	43,486	0	43,486
41. Coffee	0	0	434	434	0	434	0	434
42. Provid	0	0	122,640	122,640	0	122,640	0	122,640
43. Other	0	0	126,771	126,771	0	126,771	-126,771	0
44. Total S	0	171,231	335,070	506,301	0	506,301	-126,771	379,530
45. Grand	5,016,029	840,830	4,327,168	########	0	########	########	8,868,286

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	547,034	548,786
2. Cash - F	0	0
3. Account	2,070,425	2,070,425
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	71,574	71,574
7. Other Pr	0	0
8. Account	49,262	49,262
9. Other (s	0	0
10. Total c	2,738,295	2,740,047
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	0	634,806
14. Buildin	0	3,661,472
15. Leaseh	523,253	1,011,198
16. Equipn	438,038	1,604,898
17. Accum	-323,177	-3,433,092
18. Deferre	0	2,781
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other l	679,043	679,043
23. other (s	0	15,545
24. Total L	1,317,157	4,176,651
25. Total A	4,055,452	6,916,698
CURRENT LIABILITIES		
26. Accour	390,915	390,915
27. Officer'	0	0
28. Accour	15,701	15,701
29. Short-T	200,000	200,000
30. Accrue	236,236	236,236
31. Accrue	3,038	3,038
32. Accrue	0	141,000
33. Accrue	0	11,400
34. Deferre	0	0
35. Federa	0	0
36. Other (	180,508	183,765
37. Other (	0	0
38. Total C	1,026,398	1,182,055
LONG TERM LIABILITES		
39.Long-T	0	0
40.Mortgag	0	2,336,644
41.Bonds I	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	0	2,336,644
46.Total Li	1,026,398	3,518,699
47.Total Eo	3,029,054	3,397,999
48.Total Li	4,055,452	6,916,698

		Balance per Medicaid Trial Balance
1.	Gross F	########
2.	Discour	-597,187
	Subtota	########
4.	Day Ca	0
5.	Other C	0
6.	Therap	1,281,047
7.	Oxygen	0
	Subtota	1,281,047
9.	Paymer	0
10.	Other	0
11.	Nurse	0
12.	Gift an	467
13.	Barbe	51,586
14.	Non-P	66
15.	Teleph	202
16.	Rental	0
17.	Sale o	207,202
18.	Sale o	0
19.	Labora	17,171
20.	Radiol	3,437
21.	Other	97,589
22.	Laund	13,614
	Subtot	391,334
24.	Contril	0
25.	Interes	2,107
	Subtot	2,107
27.	Other	532,632
28.	Other	0
	Subtot	532,632
30.	Total F	########
31.	Gener	1,574,327
32.	Health	4,568,424
33.	Gener	2,122,269
34.	Owner	1,412,706
35.	Specia	383,661
35.	Provid	122,640
37.	Other	0
40.	Total E	########
41.	Incom	2,431,889
42.	Incom	0
43.	Net In	2,431,889

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Line 16 for mortgage insurance.